THE SYNDROME OF EARLY INFANTILE AUTISM

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> . . . but it has been delayed till I am indifferent, and cannot enjoy it; till I am solitary and cannot impart it . . . *Dr. Samuel Johnson.*

Psychosis in children is not common. Although it had been recognized since the early 20th Century, it was not until 1943 that Kanner first described the condition known as Early Infantile Autism. The reasons for this delayed recognition are implicit in the manifold changes which occur normally in the young child. Young children may show wide variations in mobility, speech, mood and learning ability, and it is precisely these fluctuations which render differentiation from normality difficult. Psychosis is a conflict between the ego, or self, and reality. It follows therefore that the psychotic child shows some aberration or withdrawal from reality.

In his original paper, Kanner felt that the condition was a specific form of childhood psychosis characterized by profound withdrawal and lack of contact from the very first years of life, an obsessional demand for sameness in the environment, a lack of communication in the use of language, and a preference for relationships with inanimate objects. Today autism is regarded as a syndrome occurring in early childhood, usually before the second year of life, and is characterized by an apparent difficulty in family social relationships. It is possible to delineate a pure or nuclear form in which no evidence of brain damage is demonstrable, and a mixed form in which elements of other diagnosable conditions are present. A third or borderline group exists which contains children who show features of the autistic syndrome, without gross social withdrawals i.e. some dysphasias, agnosias and apraxias.

Prevalence. Although no adequate epidemiological studies have yet been published, small surveys in the United Kingdom have suggested that one or two children out of every three thousand births are affected. The incidence is 3 to 4 times higher in boys than in girls. It is rare, though possible, to find more than one autistic child in a family.

Clinical Features

According to Mildred Creak, the following nine points describe items of behaviour commonly seen in children showing autistic behaviour.

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Normal children can show any of the behaviour mentioned at some time in their lives. Autistic children, however, show these patterns for years on end and to the exclusion of any other. The oddness of the autistic child is discernible all day and every day.

1. Gross and Sustained Impairment of Emotional Relationships with People. This shows itself in:

(a) The child's aloof and distant manner. The child behaves as though its fellow human beings did not exist, unless he is approached by people he likes.

(b) Persistent tendency to turn away from people or look past them when spoken to.

(c) Autistic children are never cuddly and never respond to being picked up.

Although parents may claim that they can "get through" to their autistic child, the children always lack outward signs of warmth towards people who do not know them.

2. Self-Examination. Preoccupation with parts of his body (i.e. hands and feet) long after the baby stage, with a tendency to examine these objects as though they had appeared spontaneously, is commonly seen.

3. Preoccupation with Objects, or Certain Characteristics of them, Without Regard to their Accepted Function Persisting Long After the Baby Stage. This may be shown in one or more of the following ways:

(a) Collecting objects of all kinds to carry around and showing great anger if any one is lost.

(b) Great attachment to one special object such as a box, a piece of cloth etc., with distress if such an object is lost.

(c) Making lines and patterns with objects regardless of their real use.

(d) Tendency to examine objects in peculiar ways e.g. listening to, biting on, and scrutinizing from peculiar angles.

(e) Odd play with objects e.g. spinning them, flicking bits of string.

4. Sustained Resistance to Change in the Environment and a Striving to Maintain Order or Sameness. This may show itself in one or more of the following:

(a) Great difficulty in changing routines and severe reactions to even minute changes.

(b) Resistance to learning new things.

(c) Great distress if familiar objects such as furniture are changed.

5. Behaviour Leading to Suspicion of Abnormalities of the Special Senses in the Absence of any Obvious Physical Cause. This may show itself in one or more of the following ways:

(a) *Speech:*

i. No reaction to speech or voice.

ii. Positive attempts to get away from some noises which occasion distress.

iii. Apparent deafness.

(b) *Vision:*

i. No reaction to things seen.

ii. Some interest in moving objects but little interest in stationary objects.

iii. Positive attempts to get away from some objects seen.

iv. Apparent blindness or short-sightedness.

(c) Apparent indifference to pain or thermal changes.

(d) Willingness to taste unusual objects with or without food faddiness.

6. Abnormalities of Mood. These may show in one or more of the following ways:

(a) Outbursts of violent and prolonged rage and distress with screaming, tears, stamping, kicking, biting, etc., brought about by change of routine, a special fear, interference by others, or for no discernible reason at all. During these outbursts the child cannot be comforted even by someone he knows and loves.

(b) Periods of laughing and giggling, for which the reasons may be obscure.

(c) Lack of fear of real dangers.

7. Speech Disturbances. These may show in one or more of the following ways:

(a) No speech at all, either from birth or it may have begun and been lost.

(b) Fragments of speech and contractions of words.

(c) Persistent simple speech as for a two year old.

(d) Reversal of pronouns e.g. "me" for "you", "he" instead of "I".

(e) Parrot-like repetitions of words, phrases, sentences or even long poems and songs without regard to meaning.

(f) Frequent use of a special voice different from that of the normal one, sometimes with special peculiarities of pronunciation.

(g) *Strange Pedantic Type of Speech.* In general the child has difficulty in communicating all but the simplest of his needs by means of speech. He may prefer to use gestures in order to show what he wants instead of asking. If these measures fail to achieve his goal, he may take people by the hand and lead them to the desired object.

8. Disturbances of Movement and General Activity. These may show in one or more of the following ways:

(a) Great overactivity, with or without sleep disturbances.

(b) Immobility.

(c) Special movements which may include rocking, head banging, jumping, twisting, flapping, writhing, spinning, facial grimacing, odd ways of walking, unusual movements of hands, repetition of the same movements, and extreme pleasure in bodily movement such as swinging, rocking, riding in cars, etc.

9. A Background of Serious Retardation in which Islets of Normal, Near Normal or Exceptional Intellectual Function may Appear. This means that, on the whole, the child is well behind his age group in performance. Unlike his normal counterpart of the same age, the autistic child requires his mother's supervision all or most of the time. In contrast to this extreme inadequacy he shows himself to be more than usually capable of performing certain tasks such as calculations, puzzles, singing and remembering music, reading and writing, memorizing long lists of dates and names, poems, odd facts, etc., even if oblivious of the meaning.

Aetiology

There is no known illness or injury which automatically produces this behaviour and no one knows why various conditions should be accompanied by autism in some children and not in others.

Schools of Thought

In this state of uncertainty many theories tend to flourish, but two schools of thought may be delineated. Firstly, there are those who believe the cause to be sociological, and secondly, there are those who believe that the primary cause is organic. It seems to the author that the two theories are not mutually exclusive, and it is probable that both views are correct; the organic or sociological factors expressing themselves to different degrees in individual cases.

1. **Psychodynamic and Sociological.** From the sociological viewpoint as typified by Kanner and Rank, autism is the mother's and/or parents' inability to create a warm emotional climate—the frigidaire atmosphere—which prevents the child's ego from developing its capacities for the externalization and taming of the drives. The result is, in Rank's words, 'a fragmented ego'. The personality structure of these children represents fragments of various stages of development showing high achievement of some of the executive functions of the ego, while other manifestations of the ego or instinctual drives remain crippled or on a much lower level.

Other workers believe that early infantile autism represents a fixation at, or a regression to, the most primitive phase of extrauterine life, and the most conspicuous symptom is that the mother, as representative of the outside world, seems not to be perceived by the child. Fundamental to the condition is a primary inability to distinguish between lifeless and living objects, as well as an inability to distinguish the self from inanimate objects in the environment.

Parental attitudes are thought to be of some importance in the genesis of the condition. Fathers of autistic children are described as often being highly intelligent with academic careers, but cold, detached, obsessional, and unable to form warm relationships. Some workers have found that almost all such parents are grossly disturbed, inconsistent, hypochondriachal, pseudo-delinquent, or even psychotic.

In this regard Goldfarb believes that the speech disturbance seen in these children, is largely determined by abnormal speech models seen in the parents.

2. **Genetic and Constitutional Factors.** There is no factual evidence available to support the thesis that autism is an inherited condition, although the frequent occurrence of similar traits in the progenitors is suggestive of a hitherto unexplained hereditary element. This contrasts with adult schizophrenia in which simple genetic mechanisms are demonstrable. Autism probably bears little relation to schizophrenia as seen in the adult.

3. **Physical Causes.** Autism may be associated with definite organic diseases, but aside from these, current investigations suggest that hormonal,

biochemical, neurological and perceptual abnormalities may be of primary significance, and this field is presently being explored.

The foregoing aetiological factors are not entirely convincing, but it must be borne in mind that methodological problems are aggrevated by the relative rarity of the syndrome, by varying therapies employed, and by adequate evaluation of the outcome, which is rendered difficult by the long period (years) required for follow up.

Differential Diagnosis

The diagnosis of autism often requires the expert services of a child psychiatrist but florid cases are difficult to miss. However, the following conditions must be distinguished from autism.

1. Mental Subnormality. Here there is usually uniform retardation in verbal and performance ability but some cases may show features of autism. Unevenness of mental development so common in autistic children is rarely seen in defective children.

2. Obsessional Neurosis. In older children, severe obsessional neurosis or the rare condition of schizophrenia of the adult type may stimulate autism.

3. Problems of Deafness or Aphasia. These can often prove difficult to exclude since autistic children rarely co-operate with objective testing procedures. Careful observation by the parents can help to establish the diagnosis. Deaf children are usually normal in other respects, although they may also show autistic behaviour, in which case there is little purpose in differentiating them from 'nuclear' autistic children.

4. Conditions Causing Brain Damage. Brain damage, regardless of aetiology, may be associated with autistic behaviour, but signs of organicity such as spasticity, or epilepsy are usually associated.

Treatment

At present, there is no treatment which can *cure* a child who shows autistic behaviour. It is therefore necessary to have realistic goals in therapy, without developing therapeutic nihilism. Much can be done to help these children develop their potentialities, and compensate for their disabilities.

The main aims in therapy are:

(a) To modify general behaviour until the child is socially acceptable even if a little odd by ordinary standards.

(b) To extend the range of motor and verbal abilities and to increase understanding of everyday life, so that the child learns to care for himself.

(c) To teach the child skills which will enable him to gain employment and earn a living in open, or, if necessary, sheltered employment.

(d) To develop any special talents that the child may have, and to widen his knowledge, so that he can find interest in life.

(e) To exploit his potential so as to make him an integral part of the community.

Medical advice should be sought as soon as possible after the diagnosis is suspected. Therapy should naturally be directed towards the entire family. It

is important, however, that mothers should have some time to themselves, in view of the great burden placed upon them by such children.

In the realm of speech therapy much can be done to correct and improve the child's powers of communication. Vocalization should be encouraged and the therapist must be careful to use speech suitable for the child's level of understanding, so as not to discourage him. At the same time his understanding and vocabulary may be increased by the gradual introduction of new words and phrases whenever he shows some spark of interest. It may fall within the speech therapist's realm to help correct the distorted body image, commonly accompanying autism, and the familiarizing of the child with parts of its body may be essential.

The child should, wherever possible, be maintained in its own home, and institutionalization should be avoided.

Summary

The theoretical orientation, symptomatology, aetiology, and management of early infantile autism has been reviewed. The important role of psychiatrist, speech therapist and parents, in the therapy of this condition is stressed.

It would seem that although the cure of autism can rarely be accomplished, early diagnosis and adequate therapy can produce improvement in many cases, and above all, prevent aggravation of the condition by a failure to understand it.

Opsomming

Die teoretiese oriëntasie, simptomatologie, etiologie en hantering van vroeë, infantiele outisme word bespreek. Die belangrike rol van die psigiater, spraakterapeut en ouers in die terapie by so 'n toestand word beklemtoon.

Alhoewel outisme selde genees kan word, kan vroegtydige diagnose en toereikende terapie tog verbetering in baie gevalle bewerkstellig en belangriker nog, verswakking van die toestand deur 'n gebrek aan begrip, uitskakel.

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